A Health Insurance Exchange in Maryland

A Presentation before the Joint Committee on Health Care Delivery and Financing

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MHCC Study

- MHCC has been asked to study the feasibility and desirability of establishing a health insurance exchange to promote expansion of affordable health care coverage in the State.

- The study will address:
  - Organization and governance of an exchange
  - Target population of an exchange
  - Functions the exchange would carry out
  - Types of products to be offered through the exchange
  - Merits of creating a separate insurance product to be administered and offered by an exchange, versus offering existing products
  - Incentives for employers and individuals to participate in an exchange
  - Impact of exchange on:
    - State's existing health insurance markets;
    - Costs of health coverage in the State to consumers; and
    - Access to health coverage in the State

- Study (cont.)
  - Role of an exchange in increasing consumer participation and choice in purchasing health coverage
  - Need to restructure the State's existing health insurance markets, including combining the individual and small group markets
  - Relationship between an exchange and insurance producers
  - Mechanisms for State oversight
  - Costs of initiating and maintaining an exchange
  - Whether participation should be mandatory or voluntary
  - Relationship of the Consumer Education and Advocacy Program to an exchange, including the need to expand the program to provide additional information to consumers regarding health insurance
  - Any lessons learned from experience in Massachusetts with an exchange

Function of a Health Insurance Exchange

- Give individuals and employees a choice among health plans
- Structure the market, providing:
  - Better competition among health plans
  - Better comparative information to guide choice
  - Greater flexibility and innovation in plan designs
- Provide portability between jobs, promoting continuity of care
- Make it possible to combine health benefits from several part time (or full time) jobs

Function of an Exchange (cont.)

- Make it simpler for employers to provide health insurance
  - Administrative burdens significantly reduced
  - Provides a way for employers who don't currently offer health benefits to contribute toward health insurance costs
- Efficiently combine individual and employer contributions with:
  - A premium support program for low-income Marylanders
  - Any available Federal tax credits for low-income individuals
- Manage risk selection among plans

Issues for Consideration

- Individual or Employer Choice
  - Currently plans are generally chosen by the employer.
  - Having not selected a plan on the basis of cost and benefits, individuals may be less inclined to accept any limitation on benefits.
  - An exchange complete with individual choice will provide a market structure that allows for competition among health plans and greater flexibility and innovation in plan designs.
  - However, choice also can result in risk selection among plans.

Issues for Consideration (cont.)

- Adverse Risk Selection
  - A pool must attract a representative range of risks, both low and high, to be able to spread risk fairly.
  - Two types of troubling pool selection can occur – those who purchase elsewhere and those who remain uninsured.
  - Purchase elsewhere:
    - Premiums must be low enough that low-cost individuals will use the pool rather than purchase policies on their own outside the pool.
    - This adverse risk problem always arises when voluntary purchasing pools must compete with what individuals can buy on their own.
    - One alternative to minimize risk selection is to establish the pool as the only means of obtaining a fully insured product in a given market.

Issues for consideration (cont.)

- Adverse Risk Selection (cont.)
  - Remaining uninsured is also problematic.
    - If the choice is due solely to low income, risk selection may be less of a problem.
    - However, if the choice is related to being young and/or healthy and deciding insurance is unnecessary until becoming ill, there is a selection problem.
    - Incentivizing purchase by lowering the price is often not very effective.
    - Instead, penalties for remaining uninsured may be necessary.
  - Final risk selection problem occurs among plans within the pool if some plans attract more healthy participants than others.
- There are several mechanisms to manage risk selection among plans:
    - Adjust premiums paid to plans based on the risks they enroll
    - Administer a plan of reinsurance or redistribute some of the premiums
    - Assure that high cost individuals receive effective disease or case management

Issues for Consideration (cont.)

- Structure of an Exchange
  - Exchange can take on many structures to meet policy needs based on reform goals and cost effectiveness.
  - All exchanges should provide a seamless way to merge employer contributions, employee deductions and subsidies.
  - Not all exchanges facilitate individual choice of plan (as opposed to employer choice).
    - A virtual exchange for the small group market could provide better information and tools to facilitate employer choice while the structure of the market and business arrangements are unchanged.
  - The exchange could also exist as a separate health plan (or choice of plans) for individuals eligible for a premium subsidy.
    - This could be made more affordable through careful core benefit design.

Structure of an Exchange (cont.)

- The exchange could operate for the small group market only.
  - Such an arrangement would allow the choice of plan to remain with the employer.
- Exchange products could be the only products available (as in current CSHBP).
- Another option could be one exchange with separate individual and small group pools and products.
  - This option would experience administrative advantages without the need to merge two different cultures and business practices or to reconcile underwriting (individual market) with modified community rating (small group market).
- An exchange can merge the individual and small group markets and restructure the market creating new roles for brokers, third party administrators, employers and plans.

MHCC Modeling

Presented During 2007 Session

- Radical Goal to be modeled: Near-universal coverage (>98%) through
  - Incentives (premium subsidies)
  - Penalties (for uninsurance)
- Principles:
  - Personal responsibility
    - must have at least catastrophic coverage - no free riders
  - Individual choice
    - Each employee can choose coverage
  - Public responsibility
    - Premium support for low income Marylanders
  - Employer responsibility
    - Offer employees access to exchange
    - Provide payroll deduction and a Section 125 premium conversion plan
    - Employer chooses a defined contribution – but is not required to contribute

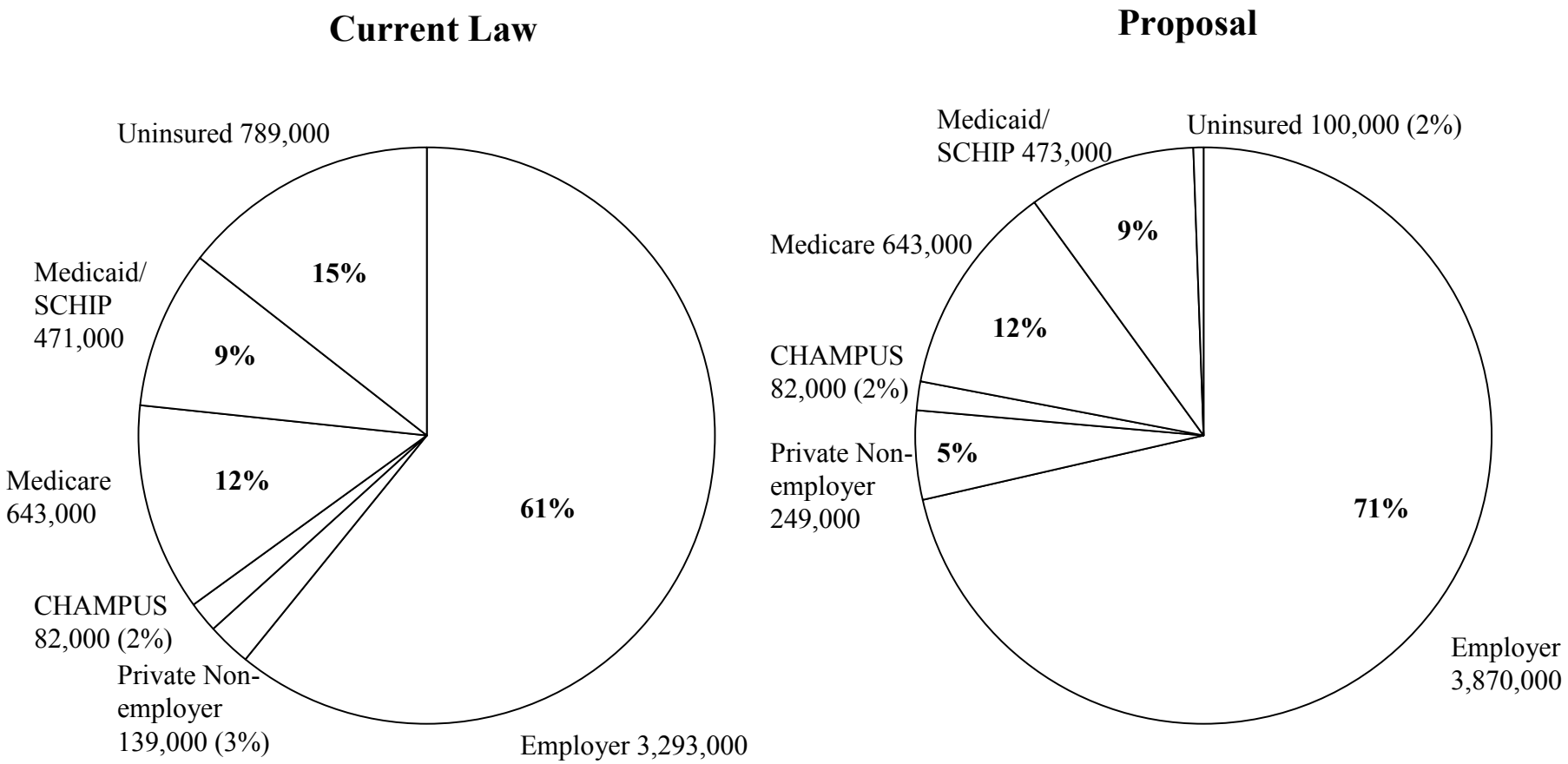
MHCC Modeling (cont.)

- Merge individual and small group markets, including MHIP
  - Guaranteed issue and renewal, modified community rating
  - Exchange is the only way to obtain fully insured coverage
- Assure broad participation through:
  - Serious penalties for remaining uninsured (75% of HDHP)
  - Generous affordability standard - sliding scale
    - Contribution to premium is $0 at incomes below 100% FPL
    - Contribution to premium is 7.5% of income at incomes from 250 to 300% FPL
- Benefit design equivalent to BC/BS Basic plan

MHCC Modeling: Key Results

- Near universal coverage (98%)
- High total cost
  - This cost can be reduced in a number of ways noted below
- Moderate government cost per newly-insured individual
  - $3,171 before offsets from existing uncompensated care fund and MHIP fund
- Substantial reduction in household expenditures
- All businesses under 100 employees have reduced health expenditures
  - Smallest firms show greatest reduction in spending ($1,262 per worker, firm <10 employees)

Distribution of Marylanders by Primary Source of Coverage Under Current Law and the Comprehensive Model



Source: Lewin Group estimates using the Health Benefits Simulation Model applied to 2007 data.

Change in Health Spending for State and Local Governments Under the Comprehensive Model in 2007 (in millions)

	Change in Spending
Medicaid Program (increased enrollment due to mandate)	**$99**
State and Local Government Workers Health Benefits Newly Covered Workers and Dependents $43 Cost of Benefits Upgrade $79 Wage Effects ($122)	**$0**
Premium Subsidy Cap	**$2,378**
Administration of Subsidies [a/]	**$116**
Savings to Safety Net Programs	**($214)**
Tax loss due to implementation of Section 125 Plans for all Employees [b/]	**$89**
Loss of Tax Revenue due to Wage Effect [b/]	**$6**
Net Cost/(Savings) to State and Local Governments	
Net Cost/(Savings)	**$2,474**

$2,474,000,000

a/ Assumes eligibility determination expense of $190 per application, which is based on a study showing the average cost of eligibility determination under the California Medicaid program

b/ Losses of tax revenues are counted as part of the cost of the program.

Source: Lewin Group estimates using the Health Benefits Simulation Model.

MHCC Modeling Results (cont.)

- Health care spending increases $1.274 billion
- Costs and savings are distributed as follows:
  - Household spending decreases $1.748 billion
  - State and local spending increases $2.474 billion
    - State and local spending would be reduced by:
      - Redirecting uncompensated hospital and trauma physician care funding
      - Redirecting MHIP high risk pool premium subsidy
      - Any federal matching achieved through state plan amendment or waiver
      - Savings in public health expenditures
  - Federal spending increases $548 million

Modeling Results (cont.)

- Reducing the cost of the option
  - Develop a high performance plan design with narrower benefits (rather than basing the plan on the FEHBP)
  - Use a high performance provider network and/or provider incentives for high quality and low cost
  - Use less generous affordability criteria to determine the subsidy
    - More household expenditure, less government expenditure
  - Require employer contributions (ERISA issues)
    - More employer expenditure, less government expenditure
  - Redesign the subsidy eligibility to reduce employer crowd-out – or try "maintenance of effort" provision
    - More employer expenditure, less government expenditure
  - Restrict subsidy eligibility to those uninsured for >6 mos.
    - More household expenditure, less government expenditure

Less comprehensive options:

More affordable (and perhaps less challenging politically)

- A virtual exchange for the small group market
  - Provides much better information and tools to facilitate employer choice
  - Structure of the market and business arrangements are unchanged
- A separate health plan (or choice of plans) for individuals eligible for a premium subsidy
  - Could be made more affordable through careful core benefit design
  - Provides way to merge employer contribution and employee withholding with state subsidy
- An exchange for the small group market only
  - Choice of plan remains with the employer
  - Exchange products are the only products available (as in current CSHBP)
  - Individual responsibility hard to apply to SGM alone
  - With or without low income subsidies

Less Comprehensive Options (cont.)

- One exchange with separate individual and small group pools and products
  - Administrative advantages
  - No need to merge two different cultures and business practices
  - No need to reconcile underwriting (individual market) with modified community rating (small group market)
  - Two design options:
    - SGM retains employer choice ➔ Structure of the market and business arrangements are unchanged
    - SGM allows individual choice ➔ Exchange handles the flow of premium and subsidy dollars through contracts with TPAs

Next Steps

- Develop high efficiency plan with narrower benefits and lower costs
  - Work initially with health plans and providers, broaden to other stakeholders
  - Address how physician reimbursement could be changed to produce greater satisfaction and superior quality – particularly since previously uncompensated physician care would now be compensated
- Understand and address other stakeholder concerns
  - Concerns of brokers and third party administrators have been prominently voiced
- Consider how Medicaid expansion through waivers or plan amendments might best be coordinated with an exchange
- Explore with stakeholders, especially hospitals, how uncompensated care funds and high risk pool funds should be mobilized to support near universal coverage
- Model the new design and less comprehensive options
- Submit report on results of the study to the House Health and Government Operations Committee and the Senate Finance Committee by Jan. 1, 2008.